TYPE OR PRINT **P69**

PUBLIC SAFETY EMPLOYEES HEALTH & WELFARE TRUST

ENROLLMENT-BENEFICIARY – RECORD CHANGE FORM

COMPLETE, ATTACH PROOF DOCUMENTS, AND RETURN IMMEDIATELY

PURPOSE FOR COMPLETING FORM
☐ Change Dependents
☐ Adoption (Date of Placement: _____)
☐ Name Change (Previous Name: _____)
☐ New Employee (See Below)
☐ Marriage Date: _____
☐ Death Date: _____
☐ Address Change (See Below)
☐ Divorce Date: _____
☐ Other: _____

EMPLOYEE SOCIAL SECURITY NO.:				EMPLOYEE BIRTHDATE:	MO.	DAY	YR.	SEX M ☐ F ☐
(Last)	(First)	(Initial)						
EMPLOYEE NAME:				OCCUPATION/ TITLE:				
MAILING ADDRESS:				NAME OF EMPLOYER:				
CITY, STATE, ZIP:				DATE EMPLOYED:				
EMAIL ADDRESS:								

LIST ELIGIBLE DEPENDENTS WHO ARE YOUR SPOUSE, ELIGIBLE DOMESTIC PARTNER*, AND DEPENDENT CHILDREN (INCLUDES NATURAL, ADOPTED, OR STEP CHILDREN UNDER AGE 26).

***Domestic Partner Affidavit must accompany this form.**
PLEASE LIST ALL ELIGIBLE DEPENDENTS.

FIRST NAME:	INT.	LAST NAME (*if different*)	SOCIAL SECURITY NUMBER (required for dependent claims payment)	RELATIONSHIP (spouse, domestic partner,* child, step child)	SEX	DATE OF BIRTH MO.	DAY	YR.	DISABLED

1. Are you, your spouse, domestic partner,***** or other dependents covered by any other group medical insurance plan?
YES _____ NO _____ If "yes", please provide the information requested.

Name of Subscriber with Other Coverage — Sub. Social Security Number

Name of Other Insurance Company — Eff. Date

Address of Other Insurance Company

City, State, Zip — Medicare Part A Eff. Date: — Medicare Part B Eff. Date:

Policy or I.D. Number

2. Who does this insurance cover?
☐ Insured Only ☐ Insured and Spouse Only
☐ Insured and Child Only ☐ Insured and Entire Family

3. What does coverage include?
☐ Medical ☐ Dental ☐ Vision ☐ Hearing

***Domestic Partner Affidavit must accompany this form.**

LIFE INSURANCE BENEFICIARY DESIGNATION:

If you select an ineligible beneficiary or do not designate a beneficiary, your death benefit(s) will be paid in the order of preference (if any) outlined in the Health and Welfare Plan.

Beneficiary Name_____ _____
(Last) (First) (Social Security Number)

Beneficiary Address _____

I CERTIFY THAT ALL ABOVE INFORMATION IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND SUPERCEDES ALL PREVIOUS FORMS SUBMITTED.

I AUTHORIZE THE EMPLOYER TO DEDUCT FROM MY EARNINGS THE AMOUNT, IF ANY, FOR THE COVERAGE SELECTED UNDER THIS PLAN.

MY CHOICE OF BENEFIT PLAN IS:
1. STANDARD PLAN _____
2. CATASTROPHIC PLAN _____

DATE_____SIGNATURE_____
(must be signed by participating member)

PRODUCT SELECTION: (FILLED IN BY TRUST)
HERITAGE PLUS ____
HERITAGE SELECT ___

RETAIN LAST COPY FOR YOUR RECORDS AND RETURN OTHER COPIES TO: PSEA HEALTH & WELFARE TRUST
P.O. BOX 93870
ANCHORAGE AK 99509-3870

(over)

PUBLIC SAFETY EMPLOYEES HEALTH & WELFARE TRUST

INSTRUCTIONS FOR NEWLY HIRED EMPLOYEES

When you enroll for coverage under this Plan you are automatically under the Standard Benefit (Heritage Network) Plan. Refer to the Benefit Comparison included with this form or on the Trust's website, www.psea.net, for coverage details. In order to select the lower cost Catastrophic Benefit plan, you must do so ***at the time of original enrollment as of your date of hire.*** You will not be allowed the opportunity to change to the Catastrophic Plan again until the next Open Enrollment period which is held each year during May/June, for coverage effective July 1st of that year.

Contribution Rates: Rates are subject to change from year-to-year by the insurance company and are contingent upon the rates each Employer agrees to contribute via the Collective Bargaining Agreement for your group, and the deduction rates approved by the Board of Trustees each year. When new rates are available, a newsletter will be sent to all Plan participants announcing the rates. Current rates are available at the Administration Office, on the website (www.psea.net) or through your Trustees.

INSTRUCTIONS FOR OTHER PARTICIPANTS

Whenever you have a change in your family status (marriage, divorce, new child, address etc.) this form must be resubmitted to change your records under the Plan. A resubmitted form must be completed in its entirety, listing all eligible dependents (spouse and/or children) and current beneficiary. This form will replace any other enrollment/beneficiary form on file at the Administration Office. However, ***Plan changes can only be done during the Annual Open Enrollment period.***

SUBMITTING YOUR FORM

Documentation regarding your dependents must be submitted with your initial form. Photo copies of your Marriage Certificate, your dependent children's Birth Certificates and Domestic Partner Affidavits (if applicable) must be submitted. Also, if you are adding dependents at a later date, such documents must be submitted with the form to support the change(s). Newly acquired dependents must be enrolled within 60 days after the date of change in family status (birth date, adoption, marriage, etc.). If the enrollment form is not received within the 60-day period, you must wait until the next annual open enrollment period to enroll your dependents for coverage.

RETAIN THIS COPY FOR YOUR RECORDS AND RETURN OTHER COPIES TO:
PSEA HEALTH & WELFARE TRUST
ADMINISTRATION OFFICE
P.O. BOX 93870
ANCHORAGE AK 99509-3870